Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST LLC
PO BOX 890008
HOUSTON TX 77289

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 20

MFDR Tracking Number
M4-12-1646-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HealthTrust originally received partial payments for the outstanding 4 dates of service in April of 2010. Only a partial payment was received because the 'medical documentation provided does not support the service (or level of service) billed'. HealthTrust constructed a reconsideration pack consisting of documentation providing the carrier with adequate medical documentation supporting all 8 hours of the program per day of service in February 2011."

Amount in Dispute: $4640.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated February 2, 2012: "The EOB (attached) reflects the reimbursement amount was proper pursuant to the State Fee Guidelines and the amount (or lack thereof) of information and description provided by the Requestor seeking reimbursement. Respondent asserts the amount of reimbursement is commensurate for the services described and provided as they are found under the Workers Compensation State Fee Guideline."

Response Submitted by: Lewis & Backhaus, PC on behalf of Dallas National Insurance Co., 5501 LBJ Frwy, Suite 800, Dallas, TX 75254

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 19, 2010 March 8, 2010 March 16, 2010 March 19, 2010	Chronic Pain Management – CPT code 97799-CP (8 hours)	$1160.00/day x 4 = $4640.00	$00.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 23, 2010
   - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - V123-CV: Medical documentation provided does not support the service (or level of service) billed.
   - W1-Workers Compensation state fee schedule adjustment.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.

   Explanation of benefits dated April 13, 2010
   - B12-Servcies not documented in patients' medical records.
   - V179-CV: CPT code submitted is based on service time and documentation does not support the time spent on this procedure.
   - W1-Workers Compensation state fee schedule adjustment.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.

   Explanation of benefits dated May 7, 2010
   - B12-Servcies not documented in patients' medical records.
   - V179-CV: CPT code submitted is based on service time and documentation does not support the time spent on this procedure.
   - W1-Workers Compensation state fee schedule adjustment.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.

   Explanation of benefits dated October 26, 2010
   - W1-Workers Compensation state fee schedule adjustment.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.

Issues

1. Did the submitted documentation support respondent's EOB denial reason codes "B12" , "150", "V123", and "V179? Is reimbursement recommended?

Findings

1. The respondent denied full reimbursement for the chronic pain management service based upon reason codes "B12-Servcies not documented in patients' medical records"; and "150-Payment adjusted because the payer deems the information submitted does not support this level of service"; "V123-CV: Medical documentation provided does not support the service (or level of service) billed"; and "V179-CV: CPT code submitted is based on service time and documentation does not support the time spent on this procedure".

   28 Texas Administrative Code §133.307(c)(2)(E) states "The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: (E) a copy of all applicable medical records specific to the dates of service in dispute."

   The Division finds that the Review of the documentation submitted by the requestor finds that the requestor has not provided medical records to support the services in dispute. The Division concludes that requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(E). Therefore, the insurance carrier's denial based upon "B12", "150", "V123", and "V179" is supported. Reimbursement cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code 133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

		4/25/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.